DRAFT

Missouri Suicide Prevention Plan

A Collaborative Effort

Year 2005-2008

Bringing a National Dialogue to the State

DRAFT

The Personal and Public Tragedy of Suicide

The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.

Kay Redfield Jamison

Suicide is the eleventh leading cause of death for adults and the third leading cause for kids.

There are many more suicides in Missouri than homicides

Every day 2 people die by suicide in Missouri

INTRODUCTION

Purpose of the Suicide Prevention Plan

"Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives."[1] "Compounding the tragedy of loss of life, suicide evokes complicated and uncomfortable reactions in most of us. Too often, we blame the victim and stigmatize the surviving family members and friends. These reactions add to the survivors' burden of hurt, intensify their isolation, and shroud suicide in secrecy."[2]

In response to national recognition of suicide as a worldwide public health problem, collaborative planning efforts began in Missouri that resulted in the passage of legislation in 2003 that mandates the development of this statewide suicide prevention plan. The Missouri Suicide Prevention Plan has been developed with broad input from public health experts, mental health providers, suicide survivors and communities across Missouri. The recommendations have been developed using reviews of research, experience of other states in suicide prevention and experience gained in suicide prevention efforts in Missouri. Broad community input was sought to tailor the scientific knowledge and national experience to address the specific needs of Missouri communities and organizations.

The planning process united various organizations and brought together partners who each play a role in identifying and solving the problem. This Plan was designed to assist stakeholders in providing services where most needed and where gaps in service exist, thus avoiding duplication and competition by suggesting ways to coordinate activities. This plan was developed to raise awareness of the suicide problem not only among the agencies and groups involved in the planning process, but also among the general population. And lastly, this plan encourages individual communities to develop customized strategies and implement them in a manner that fits their local needs and resources. All Missourians are urged to act on these recommendations to help reduce the preventable tragedy of suicide.

Suicide Prevention Principles for Missouri

A ten person working group comprised of community representatives, consumers and state agency representatives was convened to draft the plan. In developing the plan, the group envisioned the development of community based programs that:

- Enhance or strengthen protective factors and reduce the impact of risk factors.
- Promote and address help-seeking behaviors as the norm.

[1] National Strategy for Suicide Prevention, p. 17
[2] Surgeon General's Call to Action

- Are targeted to the level and type of risk of the specific population in Missouri.
- Are developmentally appropriate and culturally sensitive.
- Are focused and adapted to the specific needs of a local area's population.
- Are sustainable with repeated positive messages, prevention strategies and evaluation.

Definitions and clarifiers are included in the Appendix

SUICIDE PREVENTION AND THE PUBLIC HEALTH APPROACH

Suicide is a preventable public health problem.

There is a growing body of evidence indicating that suicide is preventable. A large number of researchers have undertaken the task of understanding the roots of suicide and preventing its occurrence. Suicide can be prevented and its impact reduced in much the same way as public health efforts have prevented and reduced other health problems, such as infectious diseases, pregnancy complications, and injuries.

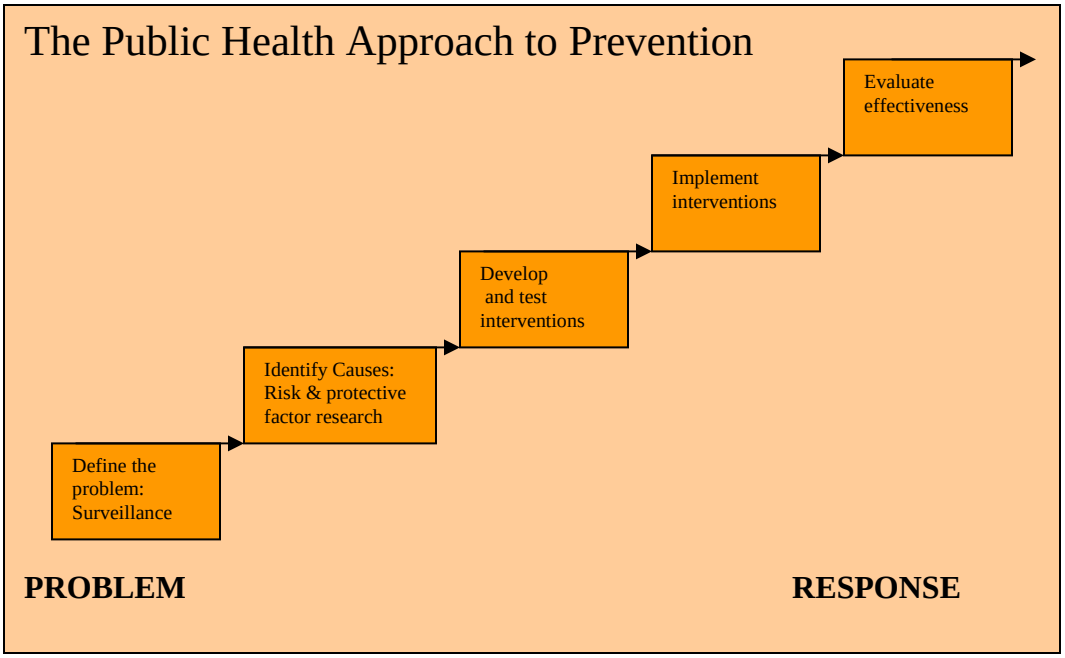
Many people find it difficult to identify suicide as a public health issue. Suicide is a major health problem because of the large number of people impacted and the enormous health care costs associated with it.

What can a Public Health Approach Contribute to Suicide Prevention?

The public health approach is a rational and systematic way to marshal prevention efforts and to assure that those efforts are effective. There are several characteristics of the public health approach that makes it the ideal way to address suicide prevention.

The public health approach to any problem is interdisciplinary and draws upon the knowledge of many disciplines. This broad knowledge base allows the field of public health to be innovative and responsive to the many different underlying issues thought to be associated with suicide and suicidal behavior. The public health approach emphasizes collective action and cooperative efforts among diverse agencies such as health, mental heath, social services, education, law enforcement and corrections. The public health approach requires individuals, communities, organizations and leaders at all levels to collaborate in promoting suicide prevention.

In concert with the clinical medical approach, which explores the history and health conditions that could lead to suicide in a single individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior throughout a group of population. The public health approach is based on the rigorous requirements of the scientific method, moving from problem to solution. It starts by defining the problem, and then identifies the risk factors, protective factors and causes of the problem. Utilizing that information, interventions are developed, implemented and evaluated for effectiveness.



Although the diagram above suggests a linear progression from the first step to the last, in reality the steps often overlap and depend upon each other. The next three sections of this report will address the specific steps of the public health model.

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DEFINING THE PROBLEM OF SUICIDE

Suicide exacts an enormous toll from the American people.

- Suicide claims more than 29,500 American lives each year[3]
- Ranked 11th cause of death in the U.S
- The rate of suicide[4] is 10.8 per 100,000 equaling 1.3% of all deaths
- Average 1 person every 17.2 minutes kills themselves
- For each completed suicide, as many as 25 people will make a non-lethal attempt

Suicide affects everyone, but some populations have higher numbers.

- Suicide is the 3rd leading cause of death for youth age 15 – 24
  - 19% of students have 'seriously considered' attempting suicide[5]
  - 8% have made a suicide attempt
- Elderly account for 18.1% of completed suicides
  - Over the age of 65, there is 1 suicide for every 4 attempts
  - 75% have seen a primary care physician within a month of their suicide

The economic burden of suicide is significant.

- Average medical cost per completed suicide exceeds $2,000[6]
  - Average work-lost cost per case exceeds $800,000
- Each day, as many as 10 suicide attempters are hospitalized
  - The medical cost per attempt averages $7,500
  - The work-lost cost per case can be as high as $10,000
  - The hospitalized rate for suicide attempts is 64.2 per 100,000

More Missourians die by suicide than by DWI, homicide, or AIDS.

- Missouri's rate of suicide*(12.9 / 100,000)* is the highest in Region VII *(Kansas, Iowa, Nebraska and Missouri)*
- Suicide is the 11th leading cause of death in Missouri[7]
- Average 707 Missourians die by suicide annually[8]
- Leading methods of suicide: firearms, suffocation, and poisoning
- Men account for 78% of completed suicides; women 22%
- 93% White non-Hispanics; 6% Black/African-American of completed suicides

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[3] American Association of Suicidology, average 1999, 2000, 2001 Official Data Pages. www.suicidology.org

[4] Suicide Rate = (number of suicides by group ÷ population of group) X 100,000

[5] Youth Risk Behavior Survey, 2001. Centers for Disease Control. www.cdc.org

[6] Suicide Prevention Resource Center, Missouri Suicide Prevention Fact Sheet; www.sprc.org

[7] Missouri Department of Health & Senior Services, Vital Statistics; Table 19 2002, 2001, 2000 www.health.state.mo.us

[8] MDHSS, Death MICA Statistics. 2002, 2001, 2000 averages. www.health.state.mo.us

RISK FACTORS AND PROTECTIVE FACTORS

The public health approach to suicide prevention often is based on decreasing risk factors associated with suicidal behavior and enhancing the protective factors. Understanding the interactive relationship between risk and protective factors in suicidal behavior continues to be studied and drives the development of interventions.

Risk Factors

Risk factors are a combination of stressful events, situations, and/or conditions that may increase the likelihood of suicide, especially when several coincide at any given time.
Risk factors for suicide include [9]:

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to suicidal behavior of others, including through media coverage and influence of others who have died by suicide

Protective Factors

Protective factors make it less likely that individuals will develop suicidal ideations; and may encompass biological, psychological or social factors in the individual, family and environment.
Protective factors include: [10]

- Effective clinical care for mental, physical, and substance use disorders

[9] National Suicide Prevention Strategy
[10] National Suicide Prevention Strategy

- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation.

INTERVENTIONS: DEVELOPMENT, IMPLEMENTATION AND EVALUATION

The first two steps of the public health model provide important information about populations impacted by suicide. Developing that knowledge into effective interventions is a central goal of public health. Researchers in the field of suicide prevention are focusing efforts on specific groups. Interventions are grouped as follows:

Universal Interventions aimed at the general population without regard to individual risk.

Selected interventions aimed at those considered at heightened risk for suicide (having one or more risk factors).

Indicated Interventions aimed at specific individuals that have a risk factor or condition that puts them at extreme high risk.

Many suicide interventions have been developed and are being implemented; most continue to be evaluated to determine their effectiveness. Some of the more common interventions include clinical treatment, behavioral and relationship approaches, community-based efforts such as suicide and crisis prevention centers, school-based interventions, restricting access to means, gatekeeper training, improved access to care, awareness campaigns, media reporting and interventions with survivors.

The development, implementation and evaluation of effective interventions in Missouri is a major goal of this plan. The plan is intended to provide broad guidelines from which communities can base local planning and implementation efforts.

Recommendation

The overall goal of a state plan for suicide prevention is to reduce suicide and suicidal behaviors in all populations. Missouri has followed the AIM framework (Awareness, Intervention, Methodology) as stated in the Surgeon General's Call to Action with recommendations for initiatives in each of the three areas, awareness, interventions, and methodology.

Suicide is a huge, complex problem and Missouri's communities are too diverse in their members and needs for a single intervention to be adequate. Thus, a diverse array of interventions will be required to meet the particular local needs of the many unique communities in Missouri. Collaboration is essential if the activities outlined in this section are to be effective.

- (Insert section about all citizenry responsible for suicide prevention efforts)
- An overarching prerequisite recommendation calls for the immediate establishment of a gubernatorial commission to monitor and oversee the effective implementation of the goals and activities set forth in this plan. The role of the commission is to assure that focus and direction is not lost during the ongoing work of the many entities that will be required to implement the activities of this plan. (covered in more detail under "Focus 3: Methodology")

Focus 1 - Awareness

In Missouri, the suicide prevention messages should be consistent among all those engaged with awareness efforts. That message should include information regarding:

- Risk and protective factors,
- That effective treatments are available for mental illness and substance abuse disorders,
- The importance of screening and early interventions,
- Reduce stigma by increasing the acceptability of asking for help around mental health issues and
- Where to go for help.

Action 1: Develop a statewide public awareness initiative designed to change attitudes toward accessing care and the availability of treatment.

- Develop public service announcements, brochures, resource guides; billboards, videos, Internet Web sites, and a speaker's bureau.
- Identify Community partnerships and collaborations to distribute information.
- Identify funds and resources to assist in local implementation of awareness efforts.

- Promote the use of national and state suicide prevention hotline numbers.
- Develop strategies to target specific groups to receive information from the public awareness initiative. These groups will include but not be limited to the following:
- Journalists, including print and broadcast media
- School boards, administrators, staff, and students.
- Social services, health, mental health and criminal justice professionals.
- Public officials, libraries, clergy
- Consumers and families
- Employer associations, unions and safety councils.
- Promote inclusion of suicide prevention as part of conferences and training that pertain to high risk populations.

Action 2: Promote activities to further investigate and implement ways to influence positive attitudes and behaviors (to seek help and to access appropriate treatment.)

Action 3: Develop training and education opportunities for providers of services to high-risk populations; including but not limited to:

- Education professionals
- Case managers
- Criminal justice professionals
- Seniors program providers
- Child and adolescent program providers
- Social services, health and mental health professionals
- Employee assistance programs
- Suicide prevention training experience should be included in
- Basic professional development courses
- Continuing education courses and workshops
- Conferences and training sessions
- Existing community based forums attended by the above groups

Action 4**:** Ensure that the suicide prevention message is consistent across agencies and that the prevention strategies and information about the risk and protective factors are integrated into suicide-related materials of all groups and agencies.

- Monitor the development of suicide prevention messages and assure that they are guided by the state plan.
- Develop a commission on suicide prevention that will keep the message consistent and complete through an identified staff to shepherd this effort in the DHSS and DMH.

Focus 2 - Interventions

Improve access and availability of services that encourage early detection, promote intervention and eliminate stigma associated with suicidal ideation/behavior

Action 5: Endorse, recommend and/or develop appropriate screening tools

- Assessment of coping and problem solving skills and help seeking behaviors
- Promote informal mental health screenings (anxiety, depression, stress, etc)
- Encourage inclusion of formal mental health screenings to the medical community
- Assure use of age appropriate tools for early identification of suicidal ideation across the lifespan

Action 6: Promote the development of gatekeeper training within communities for all citizens

- Develop community education opportunities
- Recommend gatekeeper training curriculum
- Include suicide prevention and intervention training for those working in elementary and secondary education and institutions of higher learning
- Identify key members of the community, both professional and lay persons
- Target providers of services to high-risk populations; including but not limited to
    - Education
    - Case Managers
    - Criminal justice professionals
    - Seniors program providers
    - Child & adolescent program providers
    - Social services, health and mental health professionals
    - Employee assistance programs
- Suicide prevention training component(s) should be included in
    - Professional development
    - Continuing education and refresher opportunities
    - Conferences and related enrichment
    - Community based forums

Action 7: Within prevention interventions, promote the inclusion of training for all intervention participants (not just gatekeepers) in how to access help and how to respond to friends and colleagues who might be at risk for suicide.

Action 8: Publicize community, state and national crisis telephone hotlines

- Develop community rosters of available telephone services
- Assist providers of telephone services in marketing of services

Action 9: Encourage participation of minority and non-traditional populations (caregivers, 1st responders, etc.) in the development of community based population

- Support the development of community based forums to address suicide
- Involve local communities and support local efforts to prevent suicide by assessing and acting on local risk or protective factors.
- Provide or assist in obtaining funding for prevention initiatives sponsored by local efforts.
- Facilitate formation of new suicide survivor support groups.

Action 10: Promote and encourage the use of existing local prevention and intervention resources including but not limited to:

- Mental health service providers
- Community service providers
- Opportunities to facilitate community networking; and
- Development of a community resource guide; provided via access to a data base or website

Action 11: Encourage collaboration among law enforcement, mental health and other service providers

- Implement crisis intervention teams
- Cross train staff for greater understanding of situation management and end result

Action 12: Improve capacity for primary care providers to refer patients for appropriate care

- Strive for mental health insurance parity
- Identify and reduce barriers to adequate care (transportation, provider availability, facility location, financial, work-related, etc.)

Action 13: Promote the use of follow-up protocols

- Identify and provide protective services after suicide risk has been identified (support groups, skill building/educational programs, self-enhancement activities);
- Eliminate barriers in public and private insurance programs for provision of mental health treatments; and
- Develop and implement effective training and support programs for family members of those at risk

Focus 3 - Methodology

Action 14: Establish a commission managed by the Departments of Health and Senior Services and Mental Health--to monitor and oversee the effective implementation of the goals and activities set forth in this plan. Membership should include:

- Six members from each of the following Executive Departments: Health and Senior Services, Mental Health, Social Services, Elementary and Secondary Education, Corrections and Higher Education.
- Ten members drawn from citizens representing suicide attempt survivors, family survivors, a psychiatrist or licensed psychologist, a licensed social worker or professional counselor, and representatives from law enforcement, clergy, schools and Not For Profit Researcher
- The Commission should be staffed by at least a coordinator and clerical staff person.

Action 15: The Commission will provide oversight, technical support and outcome promotion for prevention activities

- Make information on prevention and mental health intervention model available to community groups implementing suicide prevention programs
- Promote the use of outcome methods that can allow the comparison and evaluation of the efficacy (does an intervention work), effectiveness (does an intervention work in different settings), cultural competence and cost-effectiveness of plan-supported interventions, including making specific recording and monitoring instruments available for plan-supported projects
- Periodically compile outcome information on selected or model Missouri prevention projects and disseminate to stakeholders within the state
- Encourage prevention projects to conduct outcome evaluation and disseminate findings

Action 16: Develop methods to assess the occurrence of suicide attempts and suicide completions in Missouri

- The Department of Mental Health and Department of Health and Senior Services will compile and issue a bi-annual report on suicide and suicidal behaviors in Missouri using information drawn from federal, state and local sources.
- Improve reporting and the accurate surveillance of suicide and suicidal behaviors

Action 17: Promote the development of scientific knowledge in suicide prevention activities within the state and the establishment of research partnerships

- Review state suicide prevention projects for their potential to add to evidence-based prevention knowledge and their effectiveness in diverse settings and among different age, gender and ethnic subgroups.
- Foster partnerships to conduct scientific research and secure external funding

Action 18: Assess the cultural, gender and age attitudes toward getting help for depression and suicide, the barriers (stigma) related to refusing help and the attitudes of Missourians about clinical interventions for mood disorders (psychotropic medication and psychotherapy)

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U.S. Public Health Service, The Surgeon General's Call to Action to Prevent Suicide. Washington, DC: 1999. (www.surgeongeneral.gov/library/calltoaction/ calltoaction.htm)

APPENDIXES

1. HISTORY OF THE MISSOURI PLANNING PROCESS
2. EVIDENCE BASE FOR SUICIDE PREVENTION
3. SURGEON GENERAL'S CALL TO ACTION WEBSITE
4. SUMMARY NATIONAL STRATEGY FOR SUICIDE PREVENTION WEBSITE
5. GLOSSARY

APPENDIX 1

ACTING ON SUICIDE PREVENTION
MISSOURI'S ROLE IN A NATIONAL MOVEMENT

A. Call to Action

In 1998 the U.S. Surgeon General, David Satcher, identified suicide as a major public health problem. He convened more than 450 leading public health officials, mental health professionals and consumer advocates from all over the country to begin the process of addressing suicide as a significant health problem. This resulted in *The Surgeon General's Call to Action to Prevent Suicide (1999)* where Dr. Satcher established the promise that

> "We must promote public awareness that suicides are preventable. We must enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment. And we must reduce the stigma associated with mental illness that keeps many people from seeking help that could save their lives."

The Surgeon General's Call to Action to Prevent Suicide presented the nation with an initial blueprint for addressing suicide AIM

- Awareness,
- Intervention
- Methodology

AIM provided both the framework for immediate implementation of suicide prevention initiatives and also served as the foundation for development of the more comprehensive *National Strategy for Suicide Prevention.*

B. National Strategy for Suicide Prevention

In 2001 the U.S. Department of Health and Human Services, through the Surgeon General's Office issued the *National Strategy for Suicide Prevention.* The strategy identifies suicides high cost to the American nation noting that as the eighth leading cause of death in Americans, suicide kills 50% more people than homicide and twice as many people as HIV/Aids. The goal of the strategy is to provide national guidance to prevent suicide and reduce the rates of suicidal behaviors, reduce the traumatic after effects that suicide has on family and friends and to enhance the resiliency and interconnectedness of individuals and their communities. The national goals are:

1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
4. Develop and implement suicide prevention programs
5. Promote efforts to reduce access to lethal means and methods of self-harm

6. Implement training for recognition of at-risk behavior and delivery of effective treatment
7. Develop and promote effective clinical and professional practices Improve access to and community linkages with mental health and substance abuse services.
8. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media
9. Promote and support research on suicide and suicide prevention
10. Improve and expand surveillance systems

C. The *Missouri Suicide Prevention Plan 2001-2003*.

The initial *Missouri Suicide Prevention Plan 2001-2003* was developed in a collaborative process headed by then Missouri Department of Health and Missouri Department of Mental Health using a series of regional and statewide planning meetings that also included Department of Elementary and Secondary Education, Department of Corrections, community self-help groups and survivors. This plan using the AIM format lead to actions including:

1. Public awareness campaigns using radio, TV and billboards.
2. Suicide prevention training for professional caregivers including public health nurses, school counselors, gambling counselors, substance abuse counselors, probation and parole officers and others
3. Training of hundreds of Suicide Prevention Gatekeepers (gatekeepers are anyone who by virtue of their daily activity come into contact with individuals who may be at risk for suicide and can recognize and refer for help).
4. Community based efforts.

D. The Missouri Legislature takes Action

In Fall of 2003 the 92nd General Assembly passed the bipartisan House Bill #'s 59 and 269 directing the Director of the Department of Mental Health in partnership with the Department of Health and Senior Services in collaboration with other agencies and community organizations to develop a new state suicide prevention plan including but not limited to workplaces, schools and public and community health settings. The new plan shall be submitted to the general assembly by December 31, 2004 with recommendations for implementation.

Appendix II

Evidence Base for Suicide Prevention

Strategy	Rationale	Limitations	Effect
School-based Suicide Awareness Curriculum	Some research available on teenager's attitudes on help seeking behavior	▪ Some shifts in desirable attitudes ▪ some evidence of increase in maladaptive coping ▪ Possibility of contagnation.	Minor increase in knowledge and attitude shifts.
Screening	Extensive research on risk factors available from psychological autopsy studies and studies of attempters	▪ Many false positives identified ▪.Assistance in referrals to adequate treatment necessary.	If targets of screening depression, substance abuse and suicide attempts are treated the potential impact on reducing suicides is considerable.
Gatekeeper Training	Similar to CPR Trains members of general public to identify persons at risk, briefly intervene then refer person to professional	Repetition of training program appears necessary	Evidence of knowledge gain and reduction of gender specific suicidal rates
Crisis Centers and Hotlines	Psychological autopsy studies indicate that suicide is often associated with a stress event	Widely available but less apt to be used by boys	Decrease of over 1/3 in suicide rate for young white females
Restriction of lethal means	Several studies indicate availability of firearms in homes significantly increases risk of completed suicide	Second Amendment rights limit acceptability within segments of public	23% reduction in firearm suicides reported. Method substitution appears to be minimal.
Media Education	Numerous studies indicate existence of suicide contagion	Media might be reluctant to participate. Turn over of editorial staff and journalists would require repetition of education programs.	7% reduction in suicides reported in first year and 20% over 4 years post guidelines.
Postvention/crisis intervention	Several studies have examined	High risk persons are not necessarily identified without systematic screening	Not yet known.

Appendix III

SURGEON GENERAL'S CALL TO ACTION WEBSITE:

www.surgeongeneral.gov/library/calltoaction/calltoaction.htm

Appendix IV

SUMMARY NATIONAL STRATEGY FOR SUICIDE PREVENTION WEBSITE

www.mentalhealth.org/suicideprevention/strategy.org

Appendix V

Glossary
for Missouri State Suicide Prevention Plan

attempter: *an individual who makes a nonfatal suicide attempt. An attempter carries out a suicide plan but does not die as a result of their action(s)*

awareness: *broaden the public's recognition, knowledge and understanding*

best practice: *an activity or program based on the best available evidence regarding what is effective*

biopsychosocial: *biological, psychological and social elements that may influence behavior(s) (mental disorder, substance use/abuse, history, etc.)*

cause: *contributing factor or condition*

completer: *a person who intentionally caused their own death*

comprehensive suicide prevention plans: *plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting , biological, psychological and social factors*

connectedness: *closeness to an individual, group or people within a specific orgnaization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others*

culturally appropriate: *a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles,*

depression: *a collection of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack or pleasure*

environmental: *physical or social elements that influence behaviors (financial, home, relationships, etc.)*

gatekeeper: *those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as needed*

goal: *a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end rsult of the work*

intervention: *a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition*

lethality: *the potential for death*

means: *the insturment or object whereby a self-destructive act is carried out*

means restriction: *techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm*

methodology: *advance the scientific research, evaluation, and monitoring systems for the prevention of suicide and suicidal behaviors*

method: *action or technique which results in an individual inflicting self-harm*

non-lethal: *non-fatal, injury may occur*

objective: *a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often*

outcome: *a measurable change in the health of an individual or group of people that is attributable to an intervention*

postvention: *a strategy or approach that is implemented after a crisis or traumatic event has occurred*

prevention: *a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors*

protective factors: *factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment*

risk factors: *those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment*

screening tools: *those instruments and techniques used to evaluate individuals for increased risk of certain health problems; examples, questionnaires, check lists, self-assessment forms, etc.*

sociocultural: *consideration of the influences of societal &/or cultural norms, beliefs and attitudes*

stakeholders: *entities, including organizations, groups and individuals, that are affected by and contribute to decisions, consultations, and policies*

stigma: *an object, idea, or label associated with shame, disgrace, dishonor or reproach*

suicidal behavior: *a variety of activities related to thoughts and behaviors that include siucidal thinking, suicide attempts, and completed suicide*

suicide: *death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death*

surveillance: *the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings*

survivor: *family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide*

To submit comments or question please contact: MoSPP@dmh.mo.gov.